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Office of Administrative Law Judges
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Issue Date: 10 November 2004

CASE NO. 2004-BLA-05327

In the Matter of:

LLOYD A. COX,
Claimant,

v.

WESTMORELAND COAL COMPANY,
Employer,

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Joseph E. Wolfe, Esq.
For the Claimant

Douglas A. Smoot, Esq.
For the Employer

BEFORE: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act ("the Act"), 30 U.S.C. § 901, *et seq*. A formal hearing was held in Abingdon, Virginia on April 5, 2004, at which all parties were afforded a full opportunity to present evidence and argument. Director's exhibits ("DX") 1-36, Employer's exhibits ("EX") 1-4, part of 5, and 7-8, and Claimant's exhibits ("CX") 1-2 were admitted into evidence at the hearing. Part of Employer's Exhibit 5 and Employer's Exhibit 6 were excluded from the record as they would exceed the

evidence limitations of § 725.414(a)(2)(ii).[1] This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

ISSUES

Employer and Director concede that Claimant has established thirty years of coal mine employment. (DX 34; Tr. 5). The remaining issues presented in this claim are:

1. Existences of pneumoconiosis.
2. Causal relationship between pneumoconiosis and coal mine employment.
3. Total disability.
4. Total disability causation.

Procedural History and Background

This matter arises from a claim for Black Lung Benefits filed on April 16, 2002 (DX 1). The District Director made a preliminary determination to award benefits on March 11, 2003 and thereafter issued a Proposed Decision and Order awarding benefits on June 25, 2003. (DX 20, 23). Employer appealed. (DX 30). On November 14, 2003, the District Director transferred the case to the Office of Administrative Law Judges to be set for hearing (DX 34). I held a formal hearing on April 5, 2004 in Abingdon, Virginia.

Claimant is 63 years old and has no dependents. (DX 1). He alleged thirty-six years of coal mine employment. (DX 3). The parties have stipulated, and I find, that Claimant engaged in coal mine employment for thirty years. (Tr. 5; DX 5). The parties further stipulated, and the record confirms, that Westmoreland Coal Company was properly identified as the Responsible Operator in this case. (Tr. 5; DX 5; DX 22).

Existence of Pneumoconiosis

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The regulations at 20 C.F.R. § 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the claimant must establish causation by competent evidence. *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). The Board has held that the burden of proof is met under § 718.203(c) where "competent evidence establish(es) that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP*, 11 B.L.R. 1-1101-112 (1987). Specifically,

[1] The record remained open post-hearing to allow both Claimant and Employer to submit additional evidence. The deposition transcript of Dr. Kathleen DePonte was submitted by Claimant on May 28, 2004 and is admitted as CX 3 without objection. Similarly, the curriculum vitae and x-ray report of Dr. John C. Scatarige interpreting an August 7, 2003 x-ray was submitted by Employer on April 23, 2004 and is admitted as EX 9 without objection.

the record must contain medical evidence to demonstrate causation. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986)(administrative law judge cannot infer causation based solely upon claimant's employment history); *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-39 (1987) (it was error for the administrative law judge to rely solely upon lay testimony to find causation established). The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy reports; (3) the operation of a presumption; or (4) the opinion of a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R.§ 718.202(a).

Chest X-rays

Exhibit	Date of X-ray	Physician/Radiological Qualifications	Impression
DX 11	1/13/03	Forehand/ B	1/0, Category A[2]
EX 2	1/13/03	Wiot/ BCR, B	No pneumoconiosis
CX 2	3/17/03	DePonte/ BCR, B	2/2, Category B
EX 5	3/17/03	Wheeler/ BCR, B	No pneumoconiosis
CX 1	8/7/03	Patel/ BCR, B	2/2, Category A
EX 9	8/7/03	Scatarige/BCR, B	No pneumoconiosis
EX 1	9/16/03	Scott/ BCR, B	1/1
EX 2	9/16/03	Wiot/ BCR, B	No pneumoconiosis

Pulmonary Function Tests

The Miner's height was reported at sixty-five inches in four of the five pulmonary function tests, and sixty-six inches in one of the tests. For purposes of determining the qualifying disability values, I find that the Miner's height equals 65 (sixty-five) inches.

Date	Physician	Age	Height	FEV1	FVC	MVV	FEV1/FVC	Exhibit
1/13/03	Forehand	61	66	3.14	3.99	77	n/a	DX 10
9/16/03	McSharry (pre)	62	65	3.02	3.88	105	78%	EX 1
9/16/03	McSharry (post)	62	65	3.12	3.90	n/a	80%	EX 1
8/7/03	Rasmussen (pre)	62	65	2.98	3.83	117	78%	CX 1
8/7/03	Rasmussen (post)	62	65	3.07	3.76	113	82%	CX 1

Arterial Blood Gas Tests

Date	Physician	pco2	po2	Exhibit
1/13/03	Forehand (rest)	34.0	63.0	DX 10[3]

[2] This chest x-ray was read on January 13, 2003 for quality purposes only by Dr. Barrett, a Board-certified radiologist and B-reader who rated the quality of the film as "1." (DX 12).

[3] The results of this study were found acceptable by Dr. Michos, a board-certified internal medicine specialist. (DX 9).

1/13/03	Forehand (exercise)	32.0	81.0	DX 10
9/16/03	McSharry	34	83	EX 1
8/7/03	Rasmussen	34.0	82.0	CX 1
8/7/03	Rasmussen	34.0	71.0	CX 1

Medical Opinion Evidence

Dr. J. Rudolph Forehand, who is board-certified in allergy and immunology, examined Claimant on January 13, 2003. (DX 7). The Claimant reported thirty plus years of coal mine employment. Dr. Forehand recorded the Claimant was a life long non-smoker. The Claimant's symptoms included sputum production, wheeze, dyspnea, hemoptysis, chest pain, orthopnea and cough. On physical examination, Dr. Forehand observed crackles at the right base. Dr. Forehand found a January 13, 2003 chest x-ray positive for complicated pneumoconiosis. A pulmonary function study was normal. The arterial blood gas analysis showed no hypoxemia on rest or with exercise. Dr. Forehand made a cardiopulmonary diagnosis of coal workers' pneumoconiosis based upon the x-ray, physical examination, and results of the biopsy. The etiology of this condition was coal dust exposure. He found Claimant totally disabled due to significant respiratory impairment and noted pneumoconiosis was the sole cause of this condition.

Dr. T. C. Lepsch reviewed a CT scan performed on January 24, 1995. (EX 2). An area of patchy parenchymal disease in the axillary segment of the upper lobe of the right lung was noted. The opacity observed contained a few small air filled bronchi which appeared to be crowded together. There was also retraction of the pleural surface adjacent to the most peripheral extent of the opacity. Dr. Lepsch opined that these findings suggested an area of focal atelectasis and wrote that there were no mass characteristics evident. He recommended follow-up with chest x-rays to insure complete clearing of the opacity.

Dr. David Rosenberg reviewed medical evidence submitted to him by the Employer and included his findings in a February 27, 2004 report. (EX 3). Dr. Rosenberg is board-certified in internal medicine, pulmonary disease, and occupational medicine. Dr. Rosenberg assumed thirty plus years of coal mine employment in reaching his conclusions. He opined Claimant did not have the interstitial form of coal workers' pneumoconiosis (either simple or complicated) as: (1) his lung volumes have been normal without restriction; (2) chronic end-inspiratory rales have not been heard on auscultation; (3) the diffusing capacity corrected for lung volumes has been normal; and (4) on exercise, his arterial blood gas analyses have shown normal oxygenation. Dr. Rosenberg felt the biopsy sample obtained was of a bronchial wall and did not contain parenchymal tissue. He also stated the nodular changes or large opacities observed on x-ray reflected complications from chicken pox pneumonia. Dr. Rosenberg further noted that Claimant had no significant obstructive or restrictive ventilatory defect.

Dr. Rosenberg was deposed on March 31, 2004. (EX 8). He testified that he reviewed a January 24, 1995 CT scan of Claimant's chest which disclosed a mass in the lung parenchyma on the right upper lobe with focal atelectosis and no micronodularity or background changes of coal workers' pneumoconiosis. (EX 8 at 11). He opined that the history of chicken pox pneumonia reported by Claimant to Dr. Rasmussen was significant in that this condition can cause changes

on x-ray, including calcifications and granulomatous changes that leave mass-like lesions in the lungs. (EX 8 at 11-12). Such a process would be consistent with what Dr. Rosenberg observed on the CT scan he reviewed. (EX 8 at 12). He also stated the type of parenchymal changes he saw on the CT were not the type associated with coal dust exposure. (EX 8 at 12). In fact, Dr. Rosenberg testified that he observed nothing on the CT scan consistent with coal mine dust-induced lung disease. (Ex 8 at 13). Upon review of the x-ray evidence of record, Dr. Rosenberg determined there was no evidence of coal workers' pneumoconiosis. (Ex 8 at 14). While a mass lesion was present on the x-rays and on the CT scan, it was not accompanied by the micronodularity which physicians expect to see in cases of complicated coal workers' pneumoconiosis. (Ex 8 at 14-15). He testified that the calcification in the center of the mass noted by Dr. Wheeler on his x-ray interpretation was significant in that such calcification "would suggest and be consistent with an old infectious process, the chicken pox pneumonia [as well as varicella pneumonia, tuberculosis, or histoplasmosis]." (EX 8 at 15-16). Dr. Rosenberg also opined the biopsy samples were insufficient to make a diagnosis of pneumoconiosis because they were samples of bronchial tissue as opposed to parenchymal tissue. (Ex 8 at 18-19). He explained that anyone living in an industrial area would probably have black pigment in their airway, as Claimant did. (EX 8 at 19). Dr. Rosenberg also stated that there was no evidence of respiratory or pulmonary impairment which would be expected in the case of someone with complicated pneumoconiosis. (EX 8 at 21).

Dr. Kirk Hippensteel reviewed medical evidence submitted to him by the Employer and included his findings in a March 2, 2004 report. (EX 4). Dr. Hippensteel is board-certified in internal medicine and pulmonary disease. He noted that Claimant had "a significantly abnormal chest x-ray and on minute pieces of tissue obtained at bronchoscopic biopsy, has some anthracotic pigment present but he has not had any pathologic diagnosis of coal workers' pneumoconiosis made." (EX 4 at 4). He concluded that because Claimant had normal pulmonary function, normal diffusion, and normal gas exchange, he does not have complicated pneumoconiosis. Specifically, Dr. Hippensteel noted that complicated pneumoconiosis would be expected to cause some decrease in function in these objective tests. As Claimant did not have decreased function, Dr. Hippensteel opined some more localized process such as granulomatous disease or scarring from old pneumonia had caused the density in his right upper lobe. Even if simple pneumoconiosis is stipulated to, Dr. Hippensteel felt there was no evidence of any impairment from the disease.

Dr. Hippensteel was deposed on March 30, 2004. (EX 7). He stated that he considered thirty-six years of coal mine employment and a history as a nonsmoker in rendering his opinion as to Claimant's respiratory condition. (EX 7 at 9). Dr. Hippensteel reported that Claimant suffered from no pulmonary or respiratory impairment. (Ex 7 at 9). This finding was based upon the various pulmonary function studies and arterial blood gas analyses he reviewed. (EX 7 at 9). Dr. Hippensteel also opined that Claimant does not suffer from pneumoconiosis. (EX 7 at 11). Complicated pneumoconiosis is not present because the one large opacity noted in the x-ray studies was not, according to physicians who interpreted those films, surrounded by smaller opacities as would be expected with the complicated form of the disease. (Ex 7 at 11-12). Furthermore, it would be unusual for a progressive massive fibrosis lesion of the size reported in this case to not be associated with any pulmonary impairment. (EX 7 at 12). Dr. Hippensteel also referenced the one centimeter calcification found by Dr. Wheeler within the four centimeter

lesion and stated this calcification was an indicator or marker for granulomatous inflammation. (Ex 7 at 13). Granulomatous disease, he further explained, is not caused by coal dust exposure. (EX 7 at 15). When asked to list the reasons why he did not believe Claimant had complicated coal workers' pneumoconiosis, Dr. Hippensteel testified:

> He has a very large lesion on his chest x-ray that is not associated with a background of coalescing nodules in that lesion to suggest pneumoconiosis, even in its earlier stage, at the time that that CT Scan was done in 1995. He has evidence of a granulamatous type of reaction in that lesion by the x-ray as interpreted by Doctor Wheeler in March of 2003. He has no pulmonary impairment of any kind, and that is also against complicated pneumoconiosis in this man, so that those factors speak to it being a localized granulomatous process that did not affect function, and therefore, have left him with normal pulmonary function from a pulmonary standpoint to continue at any job.

(EX 7 at 17). He acknowledge that there were no medical records which he reviewed that reflected testing for tuberculosis, sarcoidosis, histoplasmosis, or any other granulomatous disease. (EX 7 at 25-26).

Dr. Rasmussen, who is board-certified in internal medicine, examined Claimant on August 7, 2003. (CX 1). He recorded a social history of Claimant as a life long nonsmoker and an occupational history of thirty-six years in the coal mine industry. Dr. Rasmussen noted symptoms of shortness of breath on exertion, chough, wheeze, paroxysmal nocturnal dyspnea, and ankle edema. On physical examination, Dr. Rasmussen noted no abnormalities. He further noted that a chest film interpreted by Dr. Patel showed category 2/2 pneumoconiosis with size A large opacities believed to represent complicated pneumoconiosis. Arterial blood gas analyses and pulmonary function studies both produced normal results. Dr. Rasmussen diagnosed complicated coal workers' pneumoconiosis based upon exposure history and the x-ray. He also noted minimal loss of lung function.

Dr. Kathleen DePonte was deposed post-hearing on April 21, 2004. (CX 3). She is board-certified as a radiologist and qualified as a B-reader. Dr. DePonte reviewed a March 17, 2003 chest x-ray and found it positive for pneumoconiosis with a 2/2 profusion and category B large opacities. (CX 3 at 3). She testified that small opacities were observed in all lung zones. (CX 3 at 4). She interpreted the x-ray as positive for complicated pneumoconiosis and testified that it showed large opacities on the background of smaller opacities. (CX 3 at 5). Dr. DePonte stated that she observed signs of progressive massive fibrosis in Claimant's chest x-ray, *i.e.*, large opacities also known as conglomerate masses. (CX 3 at 6). During the deposition, she was presented with Dr. Patel's interpretation of the August 7, 2003 film. (CX 3 at 6). She testified that Dr. Patel's interpretation of that x-ray was generally consistent with her interpretation of the March 17, 2003 chest x-ray in that he noted masses which, when added together, were greater than five centimeters which she classified as a Category B opacity rather than a Category A opacity. (CX 3 at 7). She further noted that she and Dr. Patel both agreed there was a 2/2 profusion of type p/p opacities reflected in the chest x-rays each reviewed. (CX 3 at 7). When asked to explain the reason for the differences in her interpretation of Claimant's March 17, 2003 chest x-ray and the January 13, 2003 x-ray interpretation of Dr. Wiot, Dr. DePonte testified that

she had not seen the January 2003 x-ray film but explained that the March 2003 film reflected "clear[] evidence of interstitial lung disease." (CX 3 at 15). She further testified that there was no question that the March 2003 x-ray showed small, rounded opacities and Dr. Wiot's statement that the upper lung fields were totally clear was not correct. (CX 3 at 16). Her reaction to Dr. Wiot's interpretation of the September 16, 2003 x-ray was essentially the same. During the deposition, Dr. DePonte was also shown the x-ray interpretations of the March 17, 2003 film by Drs. Wheeler, Scott, and Scatarige. (CX 3 at 19). She testified that, contrary to those physicians' opinions, the x-ray was not consistent with diagnoses of histoplasmosis, sarcoidosis, tuberculosis, or pneumonia. (CX 3 at 20). Dr. DePonte further testified that the markings reflected on the March 17, 2003 chest x-ray were "absolutely" consistent with coal workers' pneumoconiosis. (CX 3 at 21-22).

Biopsy

Claimant underwent a bronchoscopy performed by Dr. Baron on May 24, 2002. (DX 7). One specimen from the right upper lung and one specimen from the right lower lung were removed for examination. A microscopic diagnosis of benign anthracotic and fibrotic lung tissue was made upon review of both samples.

Claimant underwent a second bronchoscopy performed by Dr. Baron on October 31, 2002. (DX 7). Upon review of the samples taken, a microscopic diagnosis of reactive fibrotic proliferation associated with dense anthrosilicosis involving the right bronchial wall was made. In a note, Dr. Baron stated that "if the clinical setting is appropriate, consideration should be given to the possibility of coal workers' pneumoconiosis."

Findings of Fact and Conclusions of Law

As noted above, the existence of pneumoconiosis may be established by chest x-rays, biopsy, autopsy, regulatory presumption, or a physician's reasoned medical opinion. *See* 20 C.F.R. § 718.202(a).

Chest X-ray Evidence

A review of the radiographic interpretation evidence reveals a conflict in opinion as to whether Mr. Cox suffers from coal workers' pneumoconiosis. In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretations favorable and unfavorable may be a factor. *Wilt v. Wolverine Mining Company*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *Akins v. Director, OWCP*, 958 F.2d 49 (4th Circuit 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 B.L.R. 1-344 (1985) and *Melink v. Consolidation Coal Company*, 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). Third, because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *See Clark v. Karst-Robbins*

Coal Co., 12 B.L.R. 1-149 (1989)(en banc); *Conn v. White Deer Coal Co.*, 862 F.2d 591 (6th Cir. 1988) (limiting application of the "later evidence" rule if later chest x-ray interpretations are inconsistent with the progressive nature of pneumoconiosis). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations of one x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present. *Copley v. Arch of West Virginia, Inc.*, Case No. 93-1940 (4th Circuit June 21, 1994)(unpublished).

The chest x-ray evidence contained in the record includes four x-rays resulting in eight interpretations ranging from completely negative to findings of "Category 2/2" pneumoconiosis. I initially note that four of the eight interpretations found sufficient evidence in the x-rays to diagnose the existence of pneumoconiosis. Of those four positive findings, three were made by board-certified radiologists who are also B-readers.

In contrast, there are four interpretations of the same four x-rays which do not support a diagnosis of pneumoconiosis. All four negative interpretations were made by dually qualified physicians. As explained below, when reviewed both chronologically and qualitatively, the x-ray evidence does not support a finding of pneumoconiosis.

The first x-ray dated January 13, 2003, was interpreted by Dr. Forehand as positive for pneumoconiosis and as negative for pneumoconiosis by Dr. Wiot. (DX 11, EX 1) As Dr. Wiot is a dually qualified reader and Dr. Forehand is simply a B-reader, I find that the interpretation of Dr. Wiot outweighs that of Dr. Forehand. Accordingly, this x-ray does not support a finding of pneumoconiosis.

The second x-ray dated March 17, 2003 was found to be negative for pneumoconiosis by Dr. Wheeler and positive by Dr. DePonte. (EX 5, CX 2) Dr. Wheeler and Dr. DePonte are both B-readers and board certified radiologists. As such, this film is in equipoise.

The third x-ray dated August 7, 2003, was interpreted as positive for pneumoconiosis by Dr. Patel and negative for pneumoconiosis by Dr. Scatarige. (CX 2, EX 9) Again, both physicians are dually qualified. I therefore find this film is also in equipoise.

The fourth x-ray dated September 16, 2003, was found to be positive by Dr. Scott and negative by Dr. Wiot. (EX 1, EX 2). Since both physicians are dually qualified, I similarly find that this film is in equipoise.

As one of the x-rays of record is negative for pneumoconiosis, and the remaining films are in equipoise, I find that the overall x-ray evidence of record does not support a finding of pneumoconiosis and that pneumoconiosis has not been established pursuant to § 718.202(a).

Biopsy

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. The record in this case contains two pathology reports of tissue removed from the Claimant's lung in 2002.

The first biopsy was performed on May 24, 2002. (DX 7) Dr. Baron made a microscopic diagnosis of benign anthracotic and fibrotic lung tissue but did not diagnose pneumoconiosis. Under 20 C.F.R. § 718.202(a)(2), a finding of anthracotic pigmentation on biopsy is insufficient to establish the existence of pneumoconiosis. A second biopsy was performed on October 31, 2002. (DX 7) Anthrosilicosis was diagnosed, and Dr. Baron, who again performed the procedure, stated that "consideration should be given to the possibility of coal workers' pneumoconiosis." Reviewing this report, I find Dr. Baron's statement vague and equivocal. An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000); *United States Steel Mining Co. v. Director, OWCP*, 187 F.3d 384, 388-89 (4th Cir. 1999); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given less weight); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Dr. Baron's use of the language "consideration should be given to the possibility" calls into question the overall finding of the biopsy result, and I thus find it entitled to less probative weight.

Several physicians of record also reviewed the above-referenced biopsy reports. Dr. Rosenberg believed that the biopsy samples obtained did not contain parenchymal tissue and they therefore were not sufficient samples for the diagnosis of pneumoconiosis. (EX 3) Dr. Hippensteel similarly stated in his deposition testimony that there was not "a specific amount of tissue to say that this is coal workers' pneumoconiosis". (EX 7, p. 27) He also found the biopsies "useless" because no coal macules were recovered during the procedures. (Ex 7, p. 27)

Reviewing the results of the biopsy reports, I find persuasive the opinions of Drs. Hippensteel and Rosenberg that there were insufficient tissue samples taken during the procedures to make a diagnosis. Both Drs. Hippensteel and Rosenberg are highly credentialed physicians, both being board-certified in internal medicine and pulmonary disease. While neither physician had the benefit of conducting the biopsy or reviewing slides, they were able to review the reports of Dr. Baron. Given their excellent qualifications, I find their reports well-reasoned and well-documented. Accordingly, I find that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(2).

Regulatory Presumption

Section 718.202(a)(3) provides that it shall be presumed that a miner was suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. In light of the fact that there is some record evidence of complicated pneumoconiosis, § 718.304 is discussed below. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Similarly, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

Section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if that miner is suffering from a chronic dust disease of the lung which:

(a) When diagnosed by chest x-ray yields one or more large opacities (greater than one centimeter in diameter) and would be classified in Category A, B, or C; or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described. Provided, however, that any diagnosis made under this paragraph shall accord with acceptable medical procedures.

20 C.F.R. § 718.304. The regulation implements § 921(c)(3) of the Black Lung Benefits Act, 30 U.S.C. §§ 901-945, employing language which is "virtually the same [as that used in the Act]." *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243 (4th Cir. 1999).

With respect to the first method for establishing the presence of complicated pneumoconiosis, the Fourth Circuit has stated:

> "[B]ecause prong (A) [under § 921(c)(3)] sets out an entirely objective scientific standard" – i.e., an opacity on an x-ray greater than one centimeter – x-ray evidence provides the benchmark for determining what under prong (B) is a "massive lesion" and what under prong (C) is an equivalent diagnostic result reached by other means.

Eastern Associated Coal Corp. v. Director, OWCP, [Scarbro], 220 F3d 250, 256 (4th Cir. 2000) *citing Double B Mining*, 177 F.3d at 243. The court noted that, while a finding of complicated pneumoconiosis may be based on evidence presented under only one of the three prongs, "the ALJ must in every case review the evidence under each prong of § 921(c)(3) for which relevant evidence is presented to determine whether complicated pneumoconiosis is present." *Ibid*. It also stated:

> [I]f the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.

Ibid.

The statutory definition of "complicated pneumoconiosis" is not, according to the Fourth Circuit, congruent with a specific medical or pathological condition:

> Section 921(c)(3), which creates the irrebuttable presumption of causation, does not refer to the triggering condition as "complicated pneumoconiosis," nor does it refer to a medical condition that doctors independently have called complicated pneumoconiosis. Rather, the presumption under § 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. The statute provides three methods for establishing the existence of the condition, but these methods would not necessarily be useful as diagnostic guidelines in a clinical setting. In short, the statute betrays no intent to incorporate a purely medical definition.

Eastern Associated Coal Corp., supra, 220 F3d at 257. However, although "*complicated* pneumoconiosis" is not defined in the statute, the term "pneumoconiosis" is expressly defined both by statute and regulation. According to the statute, "pneumoconiosis" is "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). The term "pneumoconiosis" has been further defined in the Department's regulations to include both "clinical" and "legal" pneumoconiosis, which are themselves defined as follows:

> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. § 718.201(a). The term "legal" pneumoconiosis is clearly broader than "medical" or "clinical" pneumoconiosis because it also encompasses "diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nonetheless been made worse by coal dust exposure." *Clinchfield Coal Co. v. Fuller*, 180 F.3d 622, 625 (4th Cir. 1999).

Based on the foregoing, it is clear that, in order to invoke the presumption of "complicated pneumoconiosis" set forth in § 718.304, Claimant must, at a minimum, present x-ray, biopsy, or other medical evidence of one or more large opacities in the lung which are greater than one centimeter in diameter and which result from a chronic lung disease or impairment including, but not limited to, chronic restrictive or obstructive pulmonary disease. As explained below, the evidence of record does not support invocation of the presumption in this case.

Upon review of x-rays, Drs. Forehand, Patel, and DePonte noted the presence of large opacities in three of the four x-rays of record. (DX 12, CX 1, CX 2). In contrast, Drs. Wiot, Wheeler, Scatarige, and Scott found no evidence of large opacities in the x-rays which were consistent with complicated pneumoconiosis (EX 1, EX 2, EX 5, EX 9). Drs. Wiot, Wheeler, Scatarige, and Scott are all board-certified radiologists and qualified B-readers. In contrast, of the physicians finding x-ray evidence of complicated pneumoconiosis, only Drs. Patel and DePonte are dually qualified. While the numerical superiority of negative x-rays would not alone support a finding of no complicated pneumoconiosis, *see, e.g.*, *Adkins v. Director, OWCP*, 958 F.2d 49, 52 (4th Cir. 1992), the superior qualifications of the physicians rendering the negative opinions, coupled with the explanations provided for their findings, supports a determination that complicated pneumoconiosis is not established by a preponderance of the x-ray evidence.

The January 13, 2003 film was reviewed by Dr. Forehand and read as showing a Category A large opacity. Dr. Forehand, who is a B-reader but not board-certified in radiology, wrote in the narrative portion of the ILO form "biopsy-proven [coalworkers' pneumoconiosis] 10/31/02. No evidence of malignancy." (DX 11). As noted above, however, the biopsy evidence upon which Dr. Forehand relied fails to support a finding of coalworkers' pneumoconiosis. Furthermore, Dr. Wiot, a dually qualified physician, found this chest x-ray completely negative for pneumoconiosis. (EX 2). While Dr. Wiot acknowledged on the ILO form that the x-ray revealed a mass on the right, and smaller masses on the left, he explained in the narrative report accompanying the form that these masses were not evidence of coal workers' pneumoconiosis because they appeared only in the mid lung field, pneumoconiosis invariably begins in the upper lung fields, and it only moves to the mid and lower lung fields thereafter. Given Dr. Wiot's superior qualifications, I find the large opacity reading by Dr. Forehand entitled to little probative weight.

With respect to the March 17, 2003 film, Dr. DePonte concluded that the x-ray revealed numerous small rounded opacities in all lung zones and a large opacity in the right mid-lung field. (CX 3 at 3-5). However, Dr. Wheeler reviewed this same x-ray and found no evidence of parenchymal abnormalities consistent with pneumoconiosis. (EX 5). According to Dr. Wheeler, the 4 cm mass in the right mid lung disclosed a probable 1 cm central calcification which was compatible with conglomerate tuberculosis or histoplasmosis involving the lateral portion of the right hilum with a linear scar extending to the right lateral pleura. He further determined that the few scars or 8-9 mm nodules shown in the lateral periphery of the left mid and upper lung were not consistent with pneumoconiosis and were instead compatible with healed or active granulomatous disease. Although both Drs. DePonte and Wheeler are dually qualified physicians, Dr. Wheeler is also an Associate Professor of Radiology at The Johns Hopkins Medical Institutions. (EX 5). However, even without consideration of Dr. Wheeler's slightly superior qualifications, these two contrary interpretations offset each other, and this film thus does not support a finding of complicated coal workers' pneumoconiosis.

With respect to the August 7, 2003 chest x-ray, I find the report of Dr. Patel to be equivocal on the issue of complicated coal workers' pneumoconiosis. In the narrative portion of the ILO form he completed, Dr. Patel noted that the large opacity observed by him was either complicated pneumoconiosis or neoplasia. (CX 1). In contrast, Dr. Scatarige, who is also a

dually qualified physician, found no evidence of complicated pneumoconiosis on review of this same x-ray. (EX 9). Although he could not definitively determine whether the 4 cm mass in the right mid-lung was granulomatous disease, malignancy, or some other process, he affirmatively noted there was no evidence of parenchymal abnormalities consistent with pneumoconiosis. I find Dr. Scatarige's unequivocal interpretation more probative than the equivocal interpretation of Dr. Patel, and therefore find that the August 7, 2003 chest x-ray does not support a finding of complicated coal workers' pneumoconiosis.

Finally, the sole remaining chest x-ray, dated September 16, 2003, was interpreted by Drs. Scott and Wiot, both dually qualified physicians, and found not to support a diagnosis of complicated pneumoconiosis. While Dr. Scott noted the presence of small opacities in the right and left mid lung fields, he expressly wrote in the narrative portion of the ILO form that "[t]he mass on the right is not a large opacity [consistent with complicated pneumoconiosis] with such a limited background [of small opacities]." (EX 1) (underlining in original). He instead identified the 4.5 cm mass as "possibly granulomatous versus cancer." *Ibid*. Similarly, Dr. Wiot wrote in the narrative report accompanying his interpretation of the September 16, 2003 film that the x-ray showed "no evidence of coal worker's pneumoconiosis" and that the opacities shown in the x-ray were not a result of coal dust exposure. (EX 2). Given the fact that neither physician found complicated pneumoconiosis, this x-ray evidence does not support application of the § 718.304(a) presumption in this case.

While a finding of complicated pneumoconiosis may be based on evidence presented under only one of the three prongs, "the ALJ must in every case review the evidence under each prong of [20 C.F.R. § 718.304] for which relevant evidence is presented to determine whether complicated pneumoconiosis is present." *Eastern Associated Coal Corp. v. Director, OWCP, [Scarbro]*, 220 F.3d 250, 256 (4th Cir. 2000). The non-x-ray evidence is discussed below.

No finding of complicated pneumoconiosis was made in either of the two biopsy reports of record discussed above. Accordingly, complicated pneumoconiosis has not been established pursuant to § 718.304 (b).

With respect to proving complicated pneumoconiosis under § 718.304(c), Dr. Rosenberg expressly opined that complicated pneumoconiosis was not established by the medical evidence of record. In his deposition testimony he stated that chicken pox pneumonia reported by Claimant to Dr. Rasmussen was significant in that this condition can cause changes on x-ray, including calcifications and granulomatous changes that leave mass-like lesions in the lungs. (EX 8 at 11-12). The 1995 CT scan and x-rays he reviewed showed parenchymal changes which were consistent with chicken pox pneumonia and inconsistent with complicated pneumoconiosis. Specifically, Dr. Rosenberg stated that there were no micronodular findings on the background of the large opacity which is expected to be seen in cases of complicated pneumoconiosis.

Dr. Hippensteel also found that complicated pneumoconiosis was not present. He explained in his deposition testimony that it was extremely unusual for someone to have complicated pneumoconiosis and have no abnormal pulmonary function. He also stated that the large opacity observed on the CT scan and x-rays was not surrounded by smaller opacities which are normally observed in cases of complicated pneumoconiosis.

Although Dr. Rasmussen diagnosed complicated pneumoconiosis at the time of his August 7, 2003 examination of Claimant, his finding was based upon the x-ray of Dr. Patel and Claimant's history of dust exposure. As discussed above, Dr. Patel questioned whether the large mass revealed in the x-ray was representative of complicated pneumoconiosis or a neoplasm. As Dr. Rasmussen relied on this interpretation in making his overall finding, I find that opinion entitled to less probative weight than the contrary opinions of Drs. Hippensteel and Rosenberg.

The only other medical opinion supporting a diagnosis of complicated pneumoconiosis is that offered by Dr. DePonte at the time of her post-hearing deposition in this case. However, I find the opinions of Drs. Hippensteel and Rosenberg more persuasive and entitled to greater weight. While Dr. DePonte is board-certified in radiology and a B-reader, Dr. Rosenberg is board-certified in internal medicine, pulmonary disease, and occupational medicine, and he is also certified as a NIOSH B-reader. (EX 3). Similarly, Dr. Hippensteel is a B-reader and board-certified in both internal medicine and pulmonary disease. The opinions of Drs. Hippensteel and Rosenberg are based on a thorough review the x-ray, CT scan, biopsy, and other medical evidence and are well reasoned. Dr. DePonte's opinion, however, is based solely on the x-ray evidence discussed above. In light of my finding that the x-ray evidence does not support a diagnosis of complicated coal workers' pneumoconiosis, Dr. DePonte's opinion is entitled to little probative weight.

Based on the foregoing, I find that Claimant has failed to prove, by a preponderance of the x-ray, biopsy, or other medical evidence, the existence of complicated pneumoconiosis. The § 718.304 presumption is therefore not invoked.

Medical Opinion Evidence

A determination of the existence of pneumoconiosis may also be made notwithstanding a negative x-ray if a physician, exercising sound medical judgment, finds that the miner suffers from pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(4). The medical opinion must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

Dr. Forehand made a diagnosis of pneumoconiosis based upon a chest film, biopsy results, and physical examination findings. However, I find his opinion entitled to less probative weight than the opinions of other physicians of record. As is discussed above, the biopsy results upon which Dr. Forehand relied for his opinion are of little assistance in this case and do not support a finding of pneumoconiosis. Similarly, the chest film reviewed by Dr. Forehand was found to be negative for pneumoconiosis by a more qualified reader. While Dr. Forehand noted crackles in the right lung base, I find this insufficient evidence to justify a finding of pneumoconiosis. Accordingly, Dr. Forehand's opinion is neither well reasoned nor well documented, and it is entitled to little probative weight.

Dr. Rasmussen also made a finding of pneumoconiosis. His diagnosis, however, was based solely upon a history of dust exposure and a chest x-ray.[4] (CX 1). In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals acknowledged that such bases alone would not constitute "sound" medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See, e.g., Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board noted that, when a doctor relies solely on a chest x-ray and coal dust exposure history, the failure to explain how the duration of the miner's coal mine employment supports his or her conclusion that pneumoconiosis is or is not present renders the opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Id.* As Dr. Rasmussen failed to state any reason for his diagnosis of pneumoconiosis beyond the x-ray and exposure history, I find that his report is neither well-reasoned nor well-documented.

The only other medical opinion favoring a finding of pneumoconiosis is that offered by Dr. DePonte during her post-hearing deposition. (CX 3). As explained above, that opinion is based solely on her interpretation of Claimant's March 17, 2003 chest x-ray and her review of x-ray interpretation reports authored by other physicians. Since the x-ray evidence does not support a finding of pneumoconiosis, Dr. DePonte's opinion based on that evidence is neither well reasoned nor well documented.

In contrast to the foregoing, Drs. Rosenberg and Hippensteel found that pneumoconiosis was not present. Both physicians are highly qualified, being B-readers and board-certified in internal medicine and pulmonary disease. Both physicians also had the benefit of reviewing extensive medical data including reports of examining physicians, x-rays, a CT scan, biopsy reports, and other objective laboratory data. As such, I find their reports to be well reasoned and well documented and entitled to great probative weight. Accordingly, I find that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4).

Total Disability

Even if I were to find that Claimant had established the presence of pneumoconiosis, and that his pneumoconiosis was caused by his prior coal mine employment, the claim would still be denied because the medical evidence fails to establish that Claimant is totally disabled due to pneumoconiosis pursuant to § 718. 204.[5] Total disability due to pneumoconiosis under the regulation is a two-pronged element. First, Claimant must prove that he suffers from a totally disabling respiratory or pulmonary impairment. § 718.204(b)(1). Claimant must then prove that

[4] Dr. Rasmussen wrote: "The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with complicated coalworkers' pneumoconiosis. It is medically reasonable to conclude the patient has complicated coalworkers' pneumoconiosis, Category A, which arose from his coal mine employment." (CX 1). He further noted: "The only risk factor for this patient's impaired function is his coal mine dust exposure with its resultant complicated coal workers' pneumoconiosis." *Ibid*.

[5] This discussion pertains to simple pneumoconiosis only. Under the regulations, Claimant would be entitled to an irrebuttable presumption of total disability if he was found to be suffering from complicated pneumoconiosis. *See* 20 C.F.R. § 718.304.

pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. § 718.204(c)(1).

Pulmonary function study evidence, arterial blood gas study evidence, evidence of cor pulmonale with right sided congestive heart failure, and physician opinion evidence are the means available for Claimant to prove that he is totally disabled. §§ 718.204(b)(2)(i)-(iv).

None of the pulmonary function studies of record produced values indicative of total disability pursuant to the regulations. Accordingly, I find that total disability has not been established pursuant to § 718.204(b)(2)(i).

Only one of Claimant's arterial blood gas studies meet the disability criteria of § 718.204(b)(2)(ii). The resting test of Dr. Forehand performed on January 13, 2003 produced a qualifying value. Reviewing the arterial blood gas analyses in their entirety, however, I find that the bulk of the tests performed produced non-qualifying values. Accordingly, I find that total disability has not been established pursuant to § 718.204(b)(2)(ii).

Claimant has also not presented evidence of cor pulmonale with right sided congestive heart and thus fails to meet the disability criteria of § 718.204(b)(2)(iii).

The final way for Claimant to prove total disability is by reasoned and documented physician opinion evidence establishing that his respiratory or pulmonary condition would prevent him from performing his usual coal mine work. § 718.204(b)(2)(iv).

Usual coal mine work is defined as the most recent job a miner performed regularly and over a substantial period of time. *Daft v. Badger Coal Co*. 7 B.L.R. 1-124 (1984). Claimant reported to Dr. Forehand that the last job he held for more than one year was as an equipment operator. (DX 7). Claimant reported to Dr. Rasmussen that his last employment of one year or more was as a shuttle car operator. (CX 1) Comparing Claimant's accounts of his coal mine employment to the physicians statements in the record and his employment records, I find that his last job of one year or more was as a shuttle car operator.

Claimant has undergone two full pulmonary evaluations in his claim for benefits. These examinations note his work and medical histories, respiratory symptoms and findings of physical examinations, chest x-rays, pulmonary function studies, and arterial blood gas analyses. Dr. Forehand, who performed one evaluation, found Claimant totally disabled. (DX 7) Dr. Rasmussen performed the other evaluation and found only a minimal loss of lung function but an inability to perform "very heavy" work. In their medical review reports, Drs. Hippensteel and Rosenberg found no evidence of disability.

I find the report of Dr. Forehand entitled to little probative weight. He found Claimant totally disabled despite normal pulmonary function. While one arterial blood gas analysis produced a qualifying result, upon an exercise test, the results were within normal limits. As the bulk of the arterial blood gas analyses performed produced non qualifying results, I find Dr. Forehand's reliance on this single test insufficient to support his conclusion of total disability. Accordingly, his overall report is neither well reasoned nor well documented.

I similarly find the report of Dr. Rasmussen entitled to little probative weight. Dr. Rasmussen noted that Claimant's resting blood gases were normal, his oxygen transfer was minimally impaired after exercise, and he had "minimal loss of lung function." (CX 1). Thus, his conclusion that Claimant "is unable to perform very heavy manual labor" is not supported by the objective medical evidence, and his opinion is not well reasoned.

I find the reports of Drs. Rosenberg and Hippensteel to be both well reasoned and well documented with respect to the issue of total disability. The reports of these physicians are based upon the objective laboratory data of record. Accordingly, I find that Claimant has failed to established the existence of a totally disabling respiratory or pulmonary impairment pursuant to § 718.204(b)(2)(iv).

Based on the foregoing, I find that Claimant has not shown that he is totally disabled due to pneumoconiosis pursuant to § 718.204. Failure to establish this essential element of his claim is thus an alternative basis upon which benefits must be denied.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which a claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim of LLOYD COX for benefits under the Act is DENIED.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington DC 20013- 7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington DC 20210.